

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013429

STATE FILE NUMBER

FILED MAY 13 1959

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

1995

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Gen. Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>2720 Campbell</u>	
3. NAME OF DECEASED (Type or print) First <u>ROSE</u> Middle <u>EVA</u> Last <u>MARTINSON</u>		4. DATE OF DEATH Month <u>4</u> Day <u>18</u> Year <u>59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		11. BIRTHPLACE (City and state or country) <u>Ohio</u>	
13a. FATHER'S NAME <u>Henry E. Serhoss</u>		14. NAME OF HUSBAND OR WIFE <u>Martin Martinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		17. INFORMANT <u>Paul E. Martinson</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fr. Rt. femur -</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>4200F</u>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from <u>4-6-59</u> to <u>4-18-59</u> and last saw her alive on <u>4-18-59</u> Death occurred at <u>7:10 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>Abraham Gelpert</u>	
22b. ADDRESS <u>Gen. Hospital</u>		22c. DATE SIGNED <u>4-19-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-21-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>
24. FUNERAL DIRECTOR <u>Stine & McChue, Kansas City, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4-21-59</u>	
26. REGISTRAR'S SIGNATURE <u>Neve Marshall</u>			

All diseases in Part I must be causally related.

Abraham Gelpert, M.D. Medical Certification

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *J. S. Walton*

Licensed Embalmer No. *2744*

P. O. Address *K. E. 2nd*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.